Early Childhood Pre-K Health Record Supplement*

Name of Child:	**Name of Child Care Facility:**
Child's DOB:	**To Be Completed By The Physician**

1. Type Screening	2. Date Completed	3. Results	4. Recommendations/Follow up
Head Circumference (up to 2yrs old)		❑ Normal ❑ Abnormal	
Hgb/Hct		❑ Normal ❑ Abnormal	
Lead		❑ Normal ❑ Abnormal	
BMI (≥ 2 years old)		❑ Normal ❑ Counsel	
Developmental Screening Tool: ☐ PEDS ☐ ASQ ☐ Other _____		❑ No Concern ❑ Concern	

5. Medical Conditions	6. Special Care Plan Needed	7. Recommendations	8. EC Provider Use Only
Allergies/Sensitivities ❑ None • **List:**	❑ Yes ❑ No		❑ Special Care Plan completed
Medications/Treatments ❑ None • **List:**	❑ Yes ❑ No		❑ Special Care Plan completed
Special Diet prescribed by physician ❑ None • **List:**	❑ Yes ❑ No		❑ Special Care Plan completed
Behavioral Issues/Social Emotional Concerns ❑ None • **List:**	❑ Yes ❑ No		❑ Special Care Plan completed
Medical Conditions/Related Surgeries ❑ None • **List:**	❑ Yes ❑ No		❑ Special Care Plan completed

9. Physician/NP/APRN/PA or Clinic Name, Address, Zip, Phone, Fax	11. *I give my consent for my child's Health Care Provider to discuss the information on this form with my Early Childhood Provider* _____ Early Childhood Provider Name
	12. Parent/Guardian Name
10. Physician/NP/ APRN/ PA or Clinic Signature (Signature or stamp) **Date**	**13. Parent/Guardian Signature** **Date**

*Supplement to the STATE OF HAWAIʻI, DEPARTMENT OF EDUCATION, FORM 14, Rev. 2010, RS 09-1051 (Rev. of RS 06-0698)

Instructions for Completing the Early Childhood Pre-K Health Record Supplement

To Be Completed by the Physician (Please print)

1. Type of Screening: Check all that apply.

- **Head Circumference, Hgb/Hct, Lead, BMI**
- **Developmental Screening:** The screening tools listed are:
  - **PEDS**: Parent's Evaluation of Developmental Status
  - **ASQ**: Ages and Stages Questionnaire
  - **Other:** Print the name of screening tool used.

2. Date Completed

Write the date **mm/dd/year** the screening was performed. i.e., 06/01/2006.

3. Results

Mark (X) to indicate "**Normal"** or "**Abnormal", "No Concern"** or **"Concern", "Normal"** or **"Counsel".** If the box is marked abnormal, concern or counsel, please complete Box 4. Recommendations/Follow up.

4. Recommendations/Follow up

Please complete if abnormal, concern or counsel is selected.

5. Medical Conditions

Mark (X) **"None**" box for each item if the child has no **Allergies/Sensitivities**, **Medications/Treatments**, **Special Diet prescribed by physician**, **Behavioral Issues/Social Emotional Concerns**, **Medical Conditions/ Related Surgeries**. **List** type of medical condition, e.g., **Medical Condition/Related Surgeries List**: Asthma

6. Special Care Plan Needed

If child has a medical condition and the Early Childhood Provider should develop a special care plan, mark (X) **Yes**, next to the appropriate category. If child does not need a special care plan, mark (X) **No**.

7. Recommendations

Write your recommendations, e.g., "Medications must be administered by the parent before or after school hours."

8. Early Childhood Provider Use Only

This section is designated for the early childhood provider to complete if physician has marked (X) Yes in Box 6. Sample forms of the Special Care Plans can be requested from Department of Human Service (DHS) office, phone or downloaded from the Department of Human Service website.

9. Physician/NP/APRN/PA or Clinic Name

Type or print legibly physician, nurse practitioner, advanced practiced registered nurse, physician assistant or clinic name, address, zip, phone, and fax.

10. Physician/NP/ APRN/ PA, of Clinic (Signature or Stamp) and Date:

Physician, nurse practitioner, physician assistant must sign his/her name or stamp and write in the date of child's examination.

11. *"I give my consent for my child's Health Care Provider to discuss the information on this form with my Early Childhood provider."*

The Early Childhood program is encouraged to type, print legibly, or stamp the program name here prior to parent signature.

12. Parent/Guardian Name

Print the name of the Parent or Guardian

13. Parent/Guardian Signature

The Parent or Guardian must sign his/her name and write the date signed.

To be used as part of a cover letter to the preschool, parent or physician.

The purpose of the Hawaii Department of Human Services (DHS) Early Childhood Pre-K Health Record Supplement (EC-Pre-K HRS) is to provide developmentally appropriate information on the child's health, growth and developmental status for (Pre) school entry. The EC-Pre-K HRS is to be used in conjunction with the Hawaii Department of Education (DOE), Student's Health Record Form 14 2010.

The DHS EC Pre-K Health Record can be downloaded from the Hawaii Department of Human Services website, http://humanservices.hawaii.gov/ and search for Form 908. The DOE Student Health Record Form 14 can be downloaded at Department of Education website: http://www.hawaiipublicschools.org/Pages/home.aspx, click on Parents and Students, click on Enrolling in School, click on How to Enroll, look for Related Downloads and click on Student Health Record.

The child's physician is requested to complete the DOE Student Health Record Form 14 and DHS EC Pre-K Health Record Supplement. The following are directions for completing the DHS EC Pre-K Health Record Supplement.

SPECIAL CARE PLAN FOR A CHILD WITH ALLERGY

CHILD'S NAME:_____ Date of Birth: _____

FACILITY NAME: _____

Parent(s) or Guardian(s) Name: _____

Emergency Phone Numbers: Mother _____ Father _____

Primary Health Provider Name: _____ Emergency Phone: _____

Specialist's Name (if any): _____ Emergency Phone: _____

Description of Allergy: _____
_____

Describe what signs/or symptom look like:_____
_____

Describe known triggers: _____
_____

Describe treatment:_____
_____

Possible side effects: i.e.: no peanut products allowed_____
_____

Program modification: _____
_____

When to call parent/health provider regarding symptoms or failure to respond to treatment:
_____

When to consider what condition requires urgent care or reassessment: _____
_____

Physician's Name: _____

Physician's Signature: _____ Date: _____